NewsBriefs

The good news on the Medicare Physician Fee Schedule (MFS) for 2005 is the 1.5% positive increase to the Conversion Factor as required by the Medicare Modernization Act of 2003 (MMA). The 2005 Conversion Factor is 37.8975, an increase of fifty-six cents, up from last year’s conversion rate of 37.3374. However, this is the end of the MMA increases. The Medicare Update Formula is still seriously flawed and Medicare reimbursement will face an anticipated 7% drop in the conversion factor in 2006 if this is not addressed quickly by the new Republican Congress.

The MFS Final Rule was published by the Centers for Medicare and Medicaid Services (CMS) in the Federal Register on November 15, 2004. The MFS 05 Final Rule reflects the ongoing refinement of the Practice Expense Relative Value Units portion of the fee schedule formula. The AMA Ad Hoc Practice Expense Review Committee (PERC) has recommended standardized supply packages for surgical procedures as well as evaluation and management visits. PERC recommendations account for many of the small but important increases or decreases in Practice Expense RVUs.

Geographic Practice Cost Indices (GPCI) for 2005 have been updated by CMS to incorporate the latest US Census Bureau data. This update impacts ninety-two localities around the country. The majority will see a change of +/- 1% in the GPCI multiplier for their area. About twenty locations will see a positive or negative change of 2% and fourteen localities will see a greater than 2% rise or drop in the GPCI for Physician Work and Practice Expense.

CMS is required by statute to update Professional Liability Insurance Relative Value Units component of the Medicare Fee Schedule formula every five years. However, the data and methodology in the MFS proposed rule for calculating this small, but important component of Medicare physician payment suggested results that were counter-intuitive. However, in the Final Rule CMS has retained the prior year methodology but used the most current available data. The results are small incremental changes to the malpractice RVU’s for dermatology procedures.

Incentive Payments in Specialty Physician Shortage Areas
Dermatologists may now be eligible for the new 5% incentive payment to specialists providing Medicare-covered services in a physician scarcity area (PSA). Eligible physicians furnishing care in an area qualified as a physician scarcity area (PSA) for purposes of Section 413(a) of MMA would be entitled to receive this bonus payment. This incentive payment will be calculated automatically for those dermatologists serving within counties that are classified as PSA’s. CMS will shortly have a web site where a dermatologist can determine if he/she is practicing in a PSA by keying in the zip code. The 5% will automatically be added to payment for each procedure.

Payment Reform for Covered Outpatient Drugs and Biologicals
The Medicare Fee Schedule Final Rule also addresses major changes in Medicare payment for payment of drugs and biologicals as well as revised coverage for drug administration services provided by physicians. New CPT codes will be published in AMA CPT 2006. For 2005, CMS issued a series of HCPCS G codes to permit identification and payment for these services in 2005. (See related information on page 7). □

Contents

NewsBriefs ........................................................ 1
Letter From the Editor ........................................ 2
Update on UnitedHealthcare
Multiple Surgery Policy ...................................... 2
Adjacent Tissue Replacement
or Rearrangement ...................................... 4-5, 8
Appropriate Use of CPT Codes
17106-17108 ................................................ 6, 8
Update to Purchased Diagnostic Test
Billing Instructions ............................................ 7
Intramuscular Injection Coding ........................ 7
Derm Coding Consult 2004 - Index ................. 7

Derm Coding Consult is funded by an unrestricted educational grant from Biogen Idec
Letter From the Editor

Dear Derm Coding Consult Reader:

This issue provides you with clarification and guidance on two problematic dermatology coding issues: Use of the Adjacent Tissue Transfer codes (CPT 14000-14300) with illustrations regarding the measurement of various flaps, and Correct Classification of Vascular Lesions and the Appropriate use of CPT Codes 17106-17108. We hope you find these helpful. Remember, you can also access these and all archived Derm Coding Consult issues on the web site at: http://www.aad.org/professionals/Publications/DermCodingConsult.htm.

Reminder to all our readers, if you have been selected to participate in the Academy-sponsored Practice Expense Supplemental Survey (PESS) being conducted by Doane Marketing Research, please say “Yes!” when you receive the survey package. The results of this survey will be analyzed by AAD to determine if the data can be used to AAD member advantage to support the cost of dermatology practice with major health care payers such as CMS for use in the Practice Expense validation and update process. If you are selected, please participate! If you have any questions or concerns about participation in this survey, please contact me at (847) 240-1814.

Please join me in welcoming Peggy Eiden as our new Coding & Reimbursement Specialist. Peggy comes to us from the Advocate Medical Group where she was Coding Coordinator, working with physicians, and educating clinical staff and administrative staff on coding and compliance issues. Peggy is dually certified through AHIMA as a Certified Coding Specialist-Physician (CCS-P) and through the American Academy of Professional Coders as a Certified Procedural Coder (CPC). She brings fifteen years of experience in coding and medical billing to expand our Derm Coding Consult editorial team.

Best regards,

Norma L. Border, Editor

Update on Multiple Procedure Policies

UnitedHealthcare Meeting
The American Academy of Dermatology Association (AADA) met with officials of UnitedHealthcare in June to discuss ongoing contracting issues with dermatologists, obtaining correct reimbursement, explanations of benefits, and more. AADA representatives James A. Zalla, M.D., Chair, Health Care Finance Committee, and Philip Orbuch, M.D., Chair, Managed Care Task Force, brought examples supplied by dermatologists to demonstrate the problems to the company at the meeting.

Of particular interest for dermatology was UnitedHealthcare’s previous multiple surgery policy which reimbursed the first procedure at 100 percent, the second at 50 percent, and subsequent procedures at 25 percent. UnitedHealthcare has announced a change in their policy to reflect that of Medicare and other national insurance companies. According to a clarification from UnitedHealthcare’s medical director, this change will not be entirely in place for all of UnitedHealthcare’s enrollees until mid-2005.

The change will be rolled out to recontracting employer groups, both fully-insured and self-funded, and must be consistent with UnitedHealthcare’s physician contracts. However, when this transition is completed, United will reimburse physicians at 100 percent for the first procedure and 50 percent for all additional procedures performed on the same day.

Alert on Aetna Multiple Procedure Policy
Following a merger with US Healthcare, Aetna changed its previous multiple surgery payment policy from 100%-50%-50% etc., and since January 1, 2003 has only allowed 25% payment for the third or additional procedures. Dermatologists are cautioned to consider whether they can afford to provide multiple procedures for 25% of an already discounted allowable amount if their office overhead costs about 50% of collections.

Questions on this and other managed care issues can be communicated to William Brady, Manager, Practice Management, via e-mail at wbrady@aad.org or by phone at (847) 240-1824.

Editor’s Notes:
Coding and reimbursement issues are an evolving process. It is important to keep issues of Derm Coding Consult and most important to share them with your staff involved with coding and reimbursement issues. Please note that the information provided in each issue is accurate to our best ability and knowledge at the time of publication.

Mission Statement:
Derm Coding Consult is published quarterly (March, June, September and December) to provide up-to-date information on coding and reimbursement issues pertinent to dermatology practice.

VISIT DERM CODING CONSULT AT:
www.aad.org/professionals/publications
Now for your Medicare patients:

No hurdles
No hassles

NEW J Code
J0215
One of the revisions for CPT 2004 included Adjacent Tissue Transfer or Rearrangement in the Integumentary subsection. This revision was the result of an effort by the CPT Integumentary Workgroup and the CPT Editorial Panel during several CPT Editorial Panel meetings to clarify the guidelines for measuring the defect area for determining flap codes. The consensus of the workgroup was that clarification of the use and definition of the term “defect” applicable to adjacent tissue transfer was required.

The “defect” and the attending physician work involved in adjacent tissue transfer or rearrangement varies more with the type of flap utilized than with the size of the lesion removed. For instance, in some cases, the primary defect may approximate the size of the secondary defect. However, in many instances, the secondary defect area may be considerably larger than the primary defect area, depending on factors such as location, skin mobility and elasticity, or adjacent structures such as lip or eyelid. The total flap area measured will always be larger than the “hole in the skin” resulting from excision of the lesion.

This article will focus on the new guideline language that specifically defines the term “defect,” and identifies the appropriate measurement to use when selecting the correct code to report the repair provided. This term, as used for the adjacent tissue transfer codes, has had variable interpretations. Adjacent tissue transfer actually involves a primary and secondary “defect,” both of which are repaired in the adjacent tissue transfer procedure. The primary defect, by definition, is the original defect to be closed. The secondary defect is the defect created by the movement of tissue necessary to close the primary defect. Since both types of defects affect the amount of effort necessary to perform the procedure, the language included in the new guidelines now reflects the need to include both the primary and secondary defects in the measurement for this type of repair.

For years surgeons have been able to approximate the size of skin grafts in square centimeter area and measuring the defects for flap coding is just as simple. Remember that flap codes are selected in broad categories such as “defect 10 sq cm or less” or “defect 10.1 sq cm to 30.0 sq cm.” It is not critical if the defect might be somewhere between 6 sq cm and 8 sq cm - the code is the same since it is less than 10 sq cm. The area of the primary defect plus the area of the secondary defect(s) equals the total defect in sq cm as illustrated in the following diagram.
Illustration 2, a meilolabial transposition flap, shows the circular primary defect with horizontal lines and the oblique lines represent the secondary defect. The meilolabial flap is used to repair defects on the lateral side of the nose because it transfers the matching sebaceous skin from the medial cheek. The flap can be wide enough to cover one third of the side of the nose, or it can be long enough to fold on itself and recreate a lost alar rim.

Illustration 3: The A-T Flap: Circular Defect. Tumor removed as a circle
In Illustration 3, showing an A-T flap, the primary and secondary defects are similarly illustrated and both secondary defects are added together plus the area of the primary defect to determine the flap size.

Illustration 4: Double Advancement Flap
In Illustration 4, with a double advancement flap, the two obliquely lined secondary defects are measured plus the primary defect to determine total flap size. Such rectangular shaped total defects lend themselves to multiplying the length x the width to easily estimate the total sq cm area. For other geometric shaped defects, some adjustment may be necessary to approximate the total area.

In the past, some surgeons have coded flaps based on the defect following excision of the lesion, since the “defect” was not defined. The 2004 clarifications was made by the CPT Editorial Panel to more accurately define the defect size.

2004 - CPT Guidelines
For full thickness repair of lip or eyelid, see respective anatomical subsections. Excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement (eg, Z-plasty, W-plasty, V-Y plasty, rotation flap, advancement flap, double pedicle flap). When applied in repairing lacerations, the procedures listed must be developed by the surgeon to accomplish the repair. They do not apply when direct closure or rearrangement of traumatic wounds incidentally result in these configurations. Skin graft necessary to close secondary defect is considered an additional procedure. For purposes of code selection, the term “defect” includes the primary and secondary defects. The primary defect resulting from the excision and the secondary defect resulting from flap design to perform the reconstruction are measured together to determine the code.

The Adjacent tissue transfer or rearrangement procedures are described by the series of codes 14000-14300. Note that these codes are for the “Excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement (eg, Z, W-plasty, V-Y - plasty, rotation flap, advancement flap, double pedicle flap).” In other words, routine excision of the lesion, whether it is benign or malignant, is included with codes 14000-14300 and should not be reported separately.

14000 Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001 defect 10.1 sq cm to 30.0 sq cm
14020 Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021 defect 10.1 sq cm to 30.0 sq cm
14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041 defect 10.1 sq cm to 30.0 sq cm
14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061 defect 10.1 sq cm to 30.0 sq cm
14300 Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area
Hemangiomas

Hemangiomas are vascular neoplasms that enlarge by rapid cellular proliferation. They have both a proliferative phase and an involutional phase during which the lesion shrinks and vascular parenchyma is replaced with fibrous tissue. Hemangiomas may be superficial (capillary), deep (cavernous, venous), or both superficial and deep (capillary-cavernous). Whether superficial or deep, the histologic appearance is consistent throughout and involution proceeds at the same rate throughout. The clinical appearance reflects the depth of the lesion and the degree of proliferation or involution.

The hallmark of hemangiomas is a rapid proliferative phase. Growth is particularly rapid during the first six months of life but may continue until twelve months of age. Complications from the proliferative phase include ulceration and infection, especially in areas where abrasion is common. Other complications include bleeding from trauma, skeletal distortion from mass effect on underlying bone, and distortion of underlying cartilage. Lesions of the upper eyelid may obstruct the visual axis causing deprivation amblyopia with failure to develop binocular vision. Lesions of the nose may interfere with breathing.

Vascular Malformations

Malformations may be classified as capillary, venous, arterial, lymphatic, or a combination thereof, according to the type of vessels involved. They represent an abnormality of morphogenesis comprising vascular channel abnormalities. These lesions are present at birth and grow commensurate with the child. Certain types, although congenital, may not become visible or symptomatic until adolescence or adulthood. Therefore, they may appear to be acquired. The capillary and venous malformations are low flow lesions, whereas lymphatic and arterial lesions are high flow lesions. A port-wine stain is more properly called a capillary malformation. The natural history of a port-wine stain is that the vessels become progressively ectatic over time. This results in gradual darkening, thickening, and the development of nodularity. These lesions can cause bleeding and produce physical deformity.

Ectasias

Of the ectasias, the most common lesions are those now called “cherry angioma,” “spider angioma,” and “angioma serpiginosum.” It should be noted that these lesions are not tumors but rather vascular anomalies. The term telangiectasia refers to superficial cutaneous vessels visible to the human eye. These vessels measure 0.1 to 1.0 mm in diameter and represent a dilated venule, capillary, or arteriole. Telangiectasias that are arteriolar in origin are small in diameter, bright red and do not protrude above the skin surface. Those, which arise from venules, are wider, blue, and often protrude above the skin surface. Telangiectasias arising at the capillary loop are often initially fine, red lesions, becoming larger and purple or blue with time because of venous backflow from increasing hydrostatic pressure. All forms of telangiectasia are thought to occur through the release or activation of vasoactive substances under the influence of a variety of factors, such as anoxia, hormones, chemicals, infection, and physical factors which result in capillary or venular neogenesis.

Appropriate use of CPT 17106-17108

According to Mulliken and Young’s classification of vascular lesions, all hemangiomas and malformations would be categorized as vascular proliferative lesions, since they demonstrate either growth through rapid endothelial cell hyperplasia or progressive vessel dilatation. Therefore, use of codes 17106-17108 would be appropriate when treating such lesions. Ectasias on the other hand, demonstrate normal endothelial cell turnover and therefore would not be considered as vascular proliferative lesions. The use of codes 17106-17108 are not appropriate for treatment of lesions such as telangiectasia, cherry angioma, verruca vulgaris, telangiectasia associated with rosacea and psoriasis.

— continued on page 8
Update to Purchased Diagnostic Test Billing Instructions

On October 22, 2004, CMS issued a temporary Transmittal 315 instruction change, advising all suppliers/physicians that effective November 22, 2004 to bill their local carriers for all out-of-locality purchased diagnostic tests and interpretations, regardless of where the service was furnished.

This eliminates the need for dermatology practices to find out-of-locality provider numbers. Use your office address in block 32 of CMS-1500 claim form to bill for only out-of-locality purchased test/interpretation.

Please note that purchased test/interpretation done within your local carrier’s locality must still list the address where the service was actually performed.

According to the final CMS Transmittal 341*, issued October 29, 2004, out-of-locality purchased test/interpretation claims for services provided after April 4, 2005 will be paid under the local carrier’s Medicare fee schedule. This Program Transmittal 341 update can be found by accessing CMS website: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3481.pdf

Derm Coding Consult, Spring 2004 provided initial information on the new requirements for purchased tests/interpretation claims, (pg. 4). You may access back issues of Derm Coding Consult at http://www.aad.org/professionals/Publications/DermCodingConsult.htm

There will be another update on this issue in the Spring 2005 Derm Coding Consult.

Intramuscular Injection Coding

Effective January 1, 2005 Medicare coding for intramuscular injections will change. Instead of reporting CPT 90782, Medicare has established a temporary G code. Code G0351 is to be used for therapeutic/diagnostic injection. This G code is designated as a status A code, which means it is an active code and is separately payable under the fee schedule. This also means that the intramuscular injection code will no longer be bundled into the evaluation and management service (E/M), if provided.

The following is a coding example for an established Medicare patient E/M service and triamcinolone acetonide injected intramuscularly:

99212
G0351
J3301

The temporary G codes will retire when incorporated into CPT, which will happen in 2006. The G code is to be used only for Medicare claims. Other payers will still require CPT 90782 for intramuscular injections.

According to the Final Rule, Medicare will be paying for Part B drugs at 106% of the average sales price (ASP) as reported to CMS by drug manufactures quarterly. Thus, quarterly pricing updates will be issued and there may be changes in the reimbursement for drugs each quarter.

Be sure to consult your Medicare Carrier’s publication with additional information regarding the temporary G codes.

Derm Coding Consult 2004 - Index

Note: Indexes for any prior year issues are available at:
http://www.aad.org/professionals/Publications/DermCodingConsult.htm

CLIA, AADA Manual Sum 04, pg 6

CMS
  Claims Spr 04, pg 1
  Corrected claim Sum 04, pg 4
  Place of service Spr 04, pg 4
  Medicare Carrier call centers Fall 04, pg 1
  Medicare Drug Program resources Sum 04, pg 6
  Medicare Fee 2005 Proposed Rule Sum 04, pg 1
  AAD Comments Fall 04, pg 1
  Medicare Modernization Act Sum 04, pg 7
  Medicare top codes by derms Sum 04, pg 7
  National Provider Number Spr 04, pg 1,4
  Regional Offices Spr 04, pg 5

Coding
  Candida antigen ILK Sum 04, pg 4
  E/M service Sum 04, pg 5
  Etanercept Sum 04, pg 4
  Grace period Spr 04, pg 2

HCPCS Spr 04, pg 2
ICD-9-CM Spr 04, pg 8
Hyperhidrosis Sum 04, pg 2
ICD-9-CM new codes Fall 04, pg 2
Injection, intralesional kenalog Sum 04, pg 5
IV service Sum 04, pg 5
Laser treatment for acne Sum 04, pg 5
Mohs Micrographic Surgery Fall 04, pg 4-7
Pathology services Spr 04, pg 7
Post surgery bleeding Sum 04, pg 5
Trichogram Sum 04, pg 4

EMTALA
  Final rule Spr 04, pg 5

Letter from Editor Spr 04, pg 2; Sum 04, pg 2; Fall 04, pg 2;
  Win 04, pg 2

National Health Information Infrastructure Sum 04, 0g 1,8

OIG 2004 Work plan Spr 04, pg 6, 7

Practice Expense Survey Fall 04, pg 1,7-8
Adjacent Tissue Transfer or Rearrangement

— continued from page 5

Glossary:

**Advancement Flap** – An advancement flap moves directly forward without lateral movement. A triangle of skin can be excised from the base of the flap (Burow triangle) to aid in closure. An example is the V-Y advancement flap, which can be designed as a single pedicle or a bipedicle.

**Rotation Flaps** – A rotation flap is a semicircular flap that rotates about a pivot point into an adjacent defect. The secondary defect or donor defect can be closed primarily or grafted. A backcut towards the pivot point along the diameter or a triangle of skin at the base (Burow triangle) may be added to assist in rotation and closure.

**Z-plasty Flaps** – The Z-plasty is a type of transposition flap in which two triangular flaps, designed with limbs of equal length, are interposed to exchange width and length. Classically, it is designed with 60° angles, which yield the maximum length. Skin flaps can be moved to a local or distant site.

---

Appropriate Use of CPT Codes 17106-17108

— continued from page 6

However, some ectasias such as spider angioma can be so visually prominent that they are disfiguring or symptomatic because of frequent spontaneous bleeding. Therefore, the appropriateness of codes 17000-17004 for treating ectasias should be considered on an individual basis.

**References**


---

**Derm Coding Consult is underwritten by an educational grant from BIOGEN. Please be sure to thank your BIOGEN representative for this sponsorship!**